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U.S. House of Representatives
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Modernizing and Strengthening Medicare

Dear Republican Colleague:

Between 2001 and 2075, the cost of the Medicare program as a share of GDP will almost quadruple. In ten years HI Trust Fund outlays will begin to exceed tax receipts, and by 2026 the HI trust fund will be exhausted. With the retirement of the Baby Boomers, combined with escalating health costs, the Medicare program will become increasingly unsustainable. This is why the Medicare Prescription Drug and Modernization Act of 2003 includes a significant number of reforms to ensure the long term fiscal integrity of Medicare as we modernize the program by including coverage of prescription drugs and preventive benefits.

The bill creates a competitive structure for private plans to compete to provide beneficiaries better healthcare at lower cost.

Stabilize and Promote Choice for Private Medicare Plans

- Private plans have exited Medicare for two reasons: their health costs are increasing at near double digit rates while their payments are stuck at two percent increases; and the government has not been a good business partner.

- For 2004 and 2005, the bill would stabilize the Medicare Advantage program by increasing their payments at the rate of fee-for-service growth. This will encourage plans to go back into the market.

- By 2006, new enhanced fee-for-service plans (EFFs) - regional preferred provider organizations (PPOs) - would be created. Today, the majority of Americans receive their care through such plans, and yet none are currently available in Medicare.

- These PPOs are based on the same health model as the standard option Blue Cross Blue Shield plan and would offer catastrophic protection against high health costs and maximum choice of health providers.

Promoting Competition - Phase One

- In 2006, after plans re-enter the market and stabilize financially, they would begin to compete by bidding against a "benchmark," equal to the area rate for all plans.

- Beneficiaries and taxpayers would benefit from those plans that bid under the benchmark. Seventy-five percent of the total below the benchmark would go to the beneficiary, and 25 percent would be returned to the taxpayer.

- This sets in place a powerful dynamic that continually encourages seniors to choose the most efficient plans - - tailored to their individual needs - - that negotiate discounts aggressively. Seniors and taxpayers share in the savings, and the long range costs begin to come down.

Promoting Competition - Phase Two

- **Federal Employee Health Benefit program (FEHBP) competition** would begin in 2010 in areas with significant private plan penetration.

- Plans would compete against the traditional fee-for-service program for beneficiary enrollees. This competition ensures the most efficient plans become the most attractive plans because lower premiums would result. Plans that bid under the benchmark would save taxpayer and beneficiary resources.

(MORE)

- Only by harnessing competitive forces can we begin to bend the long range cost curve of the program, while continuing to provide more and better health services. Creating structures that allow competition and market forces encourages the prudent use of taxpayer resources, and will finally let us get a handle on the long term imbalances facing the Medicare program.

Other Reforms

The bill indexes the Part B deductible - currently $100 annually - to program growth. The deductible has not been changed since 1991, and currently covers just three percent of program costs. When Medicare was first enacted, the deductible covered 45 percent of costs. Beneficiaries should share the burden of increased costs with the taxpayers.

***The Medicare Prescription Drug and Modernization Act* establishes a home health copayment at 1.5 percent ($40 to $50) for every 60-day *episode* of care.** Currently, home health is the only service where there is neither a deductible nor a copayment. Public financed health care should not encourage inappropriate utilization. Low income beneficiaries and those with few visits are exempt.

Durable Medical Equipment (DME) competitive bidding would use market forces to drive down the cost of DME products for both the government and the beneficiary, saving $9.2 billion over 10 years.

- Requires multiple winners (76 percent of the winners in the demonstration were small businesses).
- Establishes first ever quality standards for suppliers.
- Exempts geographic areas in which competition does not develop, such as rural areas or others with a low population density.

Average Wholesale Price (AWP) reform is needed to curb overpayments for Medicare covered drugs which total more than $1 billion annually. Because beneficiaries pay 20 percent coinsurance on these inflated prices, it results in a $200 million annual patient tax on some of the most vulnerable Medicare beneficiaries. Under this bill, drug payments would be reformed, but physician reimbursement would be increased substantially to pay for service costs associated with the administration of this important drug regimen.

Competitive contractor reform and regulatory reform reigns in the CMS bureaucracy while promoting competition among Medicare claims processors. Once a claim processor wins a Medicare contract, it becomes a lifetime appointment. That discourages innovation and efforts to improve efficiency. The bill opens up the process by requiring re-bidding of Medicare contracts. The bill also simplifies the regulatory bureaucracy.

Competitive delivery of drug benefit will be offered by a prescription drug plan (PDP) sponsor. Within an area, a PDP sponsor would be required to offer a PDP to all beneficiaries.

- Medicare beneficiaries would have the choice to enroll in one of at least two qualifying plans.
- By ensuring competition between plans, we create incentives for plans to negotiate aggressively with drug manufacturers to hold down costs. In turn this competition will hold down premiums for beneficiaries and costs for taxpayers.
- The bill repeals the Medicaid "best price" price control, enabling taxpayers and beneficiaries to save billions in greater market-negotiated discounts from manufacturers.
- By requiring plans to assume some financial risk, they will have incentives to aggressively negotiate lower prices and costs on seniors' and taxpayers behalf.

Medicare is outdated and needs to be modernized to incorporate additional choices for seniors to get the care they want, not the care dictated by a distant bureaucracy administering a government pricing scheme. We encourage your support for these important reforms when the Medicare Modernization and Prescription Drug Act comes to the floor of the House for your consideration.

Best regards,

Bill

Bill Thomas
Chairman